

## Child and Family Ombudsman Request for Assistance:

Date of Request: [Click here to enter a date.](#)

### Who are you?

Last Name	First Name	Middle Initial
Street Address		Apt. #
City	State	Zip Code
Is your street address the same as your mailing address? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If no, please provide mailing address to receive mail:		
Street Address		Apt.#
City	State	Zip Code
Primary Phone	Home/Work/Cell	Okay to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Secondary Phone	Home/Work/Cell	Okay to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address	Okay to send an email? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### How do you know about this child or family?

<input type="checkbox"/> Child's Parent <input type="checkbox"/> Child's Legal Guardian <input type="checkbox"/> Child's Grandparent <input type="checkbox"/> Other Relative Specify	<input type="checkbox"/> Child <input type="checkbox"/> Licensed Parent <input type="checkbox"/> Community Professional or Service Provider <input type="checkbox"/> Teacher or School Employee Specify
<input type="checkbox"/> Child's Attorney <input type="checkbox"/> Parent's Attorney <input type="checkbox"/> Office of the Public Defender <input type="checkbox"/> Other Attorney Specify	<input type="checkbox"/> DPHHS Employee <input type="checkbox"/> Attorney General's Office <input type="checkbox"/> County Attorney <input type="checkbox"/> CASA/GAL Specify
<input type="checkbox"/> Law Enforcement Professional Specify	<input type="checkbox"/> Other Relationship Specify

### Optional Information:

<input type="checkbox"/> African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian American <input type="checkbox"/> Native Hawaiian Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> Caucasian <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other:	Primary Language:
	Are you hearing impaired? <input type="checkbox"/> Yes or <input type="checkbox"/> No
	Are you vision impaired? <input type="checkbox"/> Yes or <input type="checkbox"/> No
	Do you require interpretation or translation services? <input type="checkbox"/> Yes or <input type="checkbox"/> No

To report suspected child abuse or neglect, call 911 or the Child Abuse Hotline 1-866-820-5437.

**Who is the child? (If more than one child please provide name/age/birth date and gender for each child on additional pages)**

Legal Last Name	Legal First Name	Middle Initial <input type="checkbox"/> Male or <input type="checkbox"/> Female
Age	Date of Birth (month/day/year)	Sex

**Who is the responsible adult where the child lives now?**

Last Name	First Name	Relationship to Child
Current Street Address		Apt. #
City	State	Zip Code
Primary Phone	Home/Work/Cell	Okay to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Secondary Phone	Home/Work/Cell	Okay to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address		

**Does the child have an attorney?** ☐ Yes or ☐ No or ☐ Don't Know

If Yes, attorney's name if available:

Phone:

**Does the child have a Court Appointed Special Advocate (CASA) or a Guardian ad litem (GAL)?**

☐ Yes or ☐ No or ☐ Don't Know

If Yes, CASA/GAL's name if available:

Phone:

**Child's Optional Information:**

<input type="checkbox"/> African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian American <input type="checkbox"/> Native Hawaiian Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> Caucasian <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other	Primary Language:  Is the child's hearing impaired? <input type="checkbox"/> Yes or <input type="checkbox"/> No  Is the child's vision impaired? <input type="checkbox"/> Yes or <input type="checkbox"/> No  Does the child require interpretation or translation services? <input type="checkbox"/> Yes or <input type="checkbox"/> No
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**If there is more than one child in the family, please include the above information on each child on an attached piece of paper.**



**Who is the child's mother?**

Last Name	First Name	Middle Initial
Street Address		Apt. #
City	State	Zip Code
Primary Phone	Home/Work/Cell	Okay to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Secondary Phone	Home/Work/Cell	Okay to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address	Okay to send an email? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the mother have an attorney? <input type="checkbox"/> Yes or <input type="checkbox"/> No or <input type="checkbox"/> Don't Know		
If Yes, attorney's name if available:		Phone:

**Mother's Optional Information:**

<input type="checkbox"/> African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian American <input type="checkbox"/> Native Hawaiian Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> Caucasian <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other:	Primary Language:
	Is the mother hearing impaired? <input type="checkbox"/> Yes or <input type="checkbox"/> No
	Is the mother vision impaired? <input type="checkbox"/> Yes or <input type="checkbox"/> No
	Does the mother require interpretation or translation services? <input type="checkbox"/> Yes or <input type="checkbox"/> No

**Who is the child's father?**

Last Name	First Name	Middle Initial
Street Address		Apt. #
City	State	Zip Code
Primary Phone	Home/Work/Cell	Okay to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Secondary Phone	Home/Work/Cell	Okay to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address	Okay to send an email? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the father have an attorney? <input type="checkbox"/> Yes or <input type="checkbox"/> No or <input type="checkbox"/> Don't Know		
If Yes, attorney's name if available:		Phone:

**Father's Optional Information:**

<input type="checkbox"/> African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian American <input type="checkbox"/> Native Hawaiian Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> Caucasian <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other:	Primary Language:
	Is the father hearing impaired? <input type="checkbox"/> Yes or <input type="checkbox"/> No
	Is the father vision impaired? <input type="checkbox"/> Yes or <input type="checkbox"/> No
	Does the father require interpretation or translation services? <input type="checkbox"/> Yes or <input type="checkbox"/> No

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**Who is the family's Child Protection Specialist?**

Name	County	Phone Number
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**Please describe your reason for requesting Ombudsman assistance. Include as much information as you can. What happened? When, where, and who? Also, include names and contact information of other people you think have more information:**

**Help us understand how the Ombudsman can assist you. Please use additional sheets of paper as needed to explain and give us any paperwork you think will help us understand your concern:**

**Please tell us everything you have already done about this concern. For example: Have you contacted the Child Protection Specialist? Have you contacted the local supervisor? Have you contacted the Regional Administrator? Please give the name of anyone you have already contacted and tell us what happened so far.**

**What would you like to see happen for this child or family? What help to you hope to have from the Ombudsman?**

**How did you hear about the Ombudsman Office?**

<input type="checkbox"/> DPHHS Employee <input type="checkbox"/> Friend <input type="checkbox"/> Family Member <input type="checkbox"/> CASA/GAL <input type="checkbox"/> Attorney General's Office <input type="checkbox"/> Community Professional or Service Provider Specify	<input type="checkbox"/> Media (TV or radio) <input type="checkbox"/> Internet <input type="checkbox"/> Directory Assistance or Phone Book <input type="checkbox"/> CASA/GAL <input type="checkbox"/> Conference, Training, or Workshop Specify
<input type="checkbox"/> Teacher or School Employee Specify	<input type="checkbox"/> Other Specify

**If you have questions about filling out this form or would like help filling out the form, please call the Ombudsman office at 1-844-252-4453 (1-844-25CHILD) or email the Ombudsman at [dojombudsman@mt.gov](mailto:dojombudsman@mt.gov).**

**Acronyms you might see:**

CASA	Court Appointed Special Advocate	DOJ	Department of Justice
GAL	Guardian ad Litem	AG	Attorney General
CPS	Child Protection Specialist	DPHHS	Dept. of Public Health & Human Services
CFSD	Child & Family Services Division		

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